



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

January 30, 2017

Ms. Wendy Brodie, Manager
Arbors
687 Harbor Road
Shelburne, VT 05482-7698

Dear Ms. Brodie:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on December 28, 2016. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

A handwritten signature in cursive script that reads "Pamela M. Cota RN".

Pamela M. Cota, RN
Licensing Chief



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/28/2016
NAME OF PROVIDER OR SUPPLIER ARBORS		STREET ADDRESS, CITY, STATE, ZIP CODE 687 HARBOR ROAD SHELBURNE, VT 05482			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
R100	Initial Comments: The Division of Licensing and Protection conducted an unannounced onsite investigation of a facility self report on 12/28/16. A regulatory violation was cited as a result.	R100	Action to correct the deficiency:		
R126 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide necessary services to meet 1 applicable resident's nursing and medical care needs (Resident #1). Findings include: Per record review, Resident # 1 was not provided care related to falls as per the service plan. Resident # 1 was deemed to be a high fall risk upon admission to the facility on 4/3/16. A fall risk assessment was scored at 22, indicating highest fall risk. A physical therapy evaluation was done on 4/6/16. A contact guard was recommended for ambulation. A service plan was put into place indicating high fall risk and contact guard with gait belt was to be used for all ambulation. A second service plan was put into place on 5/4/16. This plan indicated that the resident was a moderate fall risk and did not include contact guard. Per review of nursing notes, Resident # 1 fell 7 times	R126	<ul style="list-style-type: none"> * Resident number 1 no longer lives at The Arbors. * Upon admission and with every reassessment, a fall assessment is done, with risk and interventions included on service plan. Resident care staff will be oriented to the service plan and have a copy available to them. (immediate and ongoing) • When resident falls, resident risk will be reviewed and interventions considered. Service plan will be updated with new interventions, if applicable. Resident care staff will be oriented to service plan changes; and a copy available to them. (immediate and ongoing) 		
			Measures to ensure the deficiency does not recur:		
			<ul style="list-style-type: none"> • Harbor Care Director and Resident Care Director/ nurse supervisors will continue to oversee care staff to verify follow-through of service plan. (immediate and ongoing) • Weekly interdisciplinary tracking meeting will continue to be held to review each resident and change in status. 		

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

7S1611

If continuation sheet 1 of 2

R126 POC accepted 1/26/17 RRemblay/rs/pml

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R126	Continued From page 1 while at the facility. 4 of the falls were between 4/4/16 - 4/23/16 when the high risk service plan with contact guard was in effect. Several nursing notes during this time frame indicated that the resident was ambulating independently. The nurse that produced the 5/4/16 service plan stated that the plan was changed from high risk to moderate risk because the resident had become more stable with ambulation. This nurse stated that h/she was unaware that Resident # 1 had had 4 falls between 4/4/16 - 4/23/16. On 12/28/16 at 12:20 PM, the facility Executive Director confirmed that there was no indication that a contact guard was used for Resident #1 as indicated on the service plan. A facility Physical Therapist also confirmed at the time that a contact guard had been recommended and should have been in use.	R126	<p>Therapy providers attend tracking to promote collaborative care of residents. (ongoing weekly)</p> <ul style="list-style-type: none"> Nursing team will be retrained on resident assessment process and fall process by 2/18/2017 date. <p>How the corrective action will be monitored:</p> <ul style="list-style-type: none"> Resident Care Director will monitor for ongoing compliance. Monthly safety meetings will continue to be held by Executive Director/or designee. Fall trends are reviewed at safety committee Review compliance with fall risk and service plan accuracy and staff follow thru to be reported quarterly a QA committee meeting 		